Your Benefits. Your Choice.

2016 County of San Diego Employee Benefits Guide

The County of San Diego provides a comprehensive flexible benefits program for eligible employees and their dependents. The different types of plans and levels of coverage the program offers enable employees to tailor a program of benefits that best meets their needs.

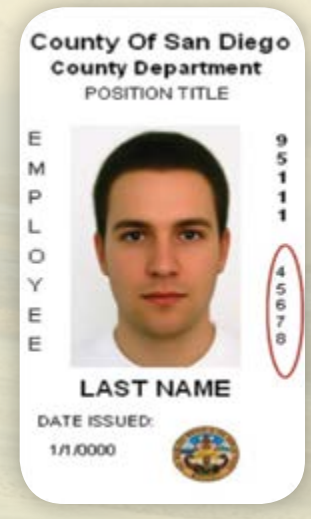
To tailor your benefits program, you must enroll for the benefits you want and waive coverage you don't want. This guide walks you through the information you need to make decisions about your County of San Diego benefits and complete the enrollment process.

CONTENTS

This guide provides general benefit plan information only. For specific details, conditions, and exclusions please refer to the official Summary Plan Descriptions (SPD). If there is a discrepancy between this guide and official SPDs, the official documents will govern.

Preparing for Enrollment

- Review all your enrollment materials, including this enrollment guide and the 2016 medical plan comparison charts on pages 18 and 19, to become familiar with your options.
- Gather your dependents' information such as Social Security numbers and dates of birth (adult dependents up to age 26).
- Determine how much — if anything — you want to contribute to the Health Care, Dependent Care Flexible Spending Accounts, or Health Savings Account.
- **Have your Employee ID number ready. You can find this number on your ID card.**
- Scan and save any documents that you will be submitting as Proof of Relationship or Proof of Other Coverage (you will need to upload these documents).



How to Enroll

Enrolling in your County benefits is easy three step process. Here's what you need to do.

Enrollment in eBenefits: PeopleSoft 9.2

1. LOG ON	2. ENROLL	3. SUBMIT
Step 1: Log on to **PeopleSoft eBenefits** **Step 2:** At the benefits Login Screen please enter your user ID and password: – User ID: Your six digit Employee ID – Password: Your PeopleSoft Self-Service Password **Step 3:** Click the "Sign In " Button	• Once you are logged in to the PeopleSoft eBenefits, select the "Enrollment" button • For Enrollment instructions, select "2016 Enrollment Instructions"	• After you complete your enrollment click "Submit" on the Benefits Enrollment page • At the "Submit Benefit Choice" screen, select "Submit" • Review and print a copy of your benefits confirmation statement for your records

Making Changes During the Year

During the year, you can only make changes to your benefits if you experience a qualifying event. "Qualifying events" include:

- Marriage, annulment of marriage, or divorce
- Legal separation
- Entering into or terminating a domestic partnership
- Adoption, placement for adoption, or birth of your child
- Leave of absence (under certain circumstances)
- Child's gain or loss of coverage
- Spouse's gain or loss of coverage

You have 60 days from the date of the qualifying event to make changes to your County of San Diego benefit elections. Any change you make must be consistent with the qualifying event change.

Your Costs for Coverage

The County of San Diego's flexible benefit program provides you with a pay period* allowance known as your Flex Credit amount that you can use to purchase benefits. It can be applied toward the cost of your health care plans, various supplemental insurances, and Health Reimbursement or Health Savings Accounts (HRA or HSA).

*Excluding the third pay periods in the months of July and December.

Online Beneficiary Management

The County makes it easy and convenient for you to designate or update your beneficiaries.

You can easily use the online eBenefits site to make your beneficiary designations. The eBenefits site allows you to quickly designate and update beneficiary information anytime while you are at work.

Beneficiaries can be changed as often as circumstances change and the changes are effective immediately. You can even print out a record to store with other important papers. For more instructions, visit the **eBenefits website.**

Domestic Partner Benefits and Flex Credits

- If you enroll a domestic partner in dental or vision coverage, the premiums will be deducted from your paycheck on a post-tax basis in compliance with IRS rules.
- Per IRS guidelines, adding a domestic partner to your benefits will result in taxable income for federal income tax purposes only.

Excess Flex Credits

You may have excess Flex Credits if you waive health care coverage or if you elect a medical plan that costs less than your Flex Credit allowance. Based on newly imposed IRS limits to employer contributions in the Health Care Flexible Spending Account (FSA), any excess Flex Credits will be directed to the respective reimbursement account based on your medical coverage election. The following table shows how the excess Flex Credits will be routed:

	HEALTH SAVINGS ACCOUNT (HSA)	HEALTH REIMBURSEMENT ACCOUNT (HRA)	HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFSA)	DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DCFSA)
IF YOU WAIVE COUNTY MEDICAL COVERAGE:				
Because You Have Individual Coverage, Such As – TRICARE; Medicare; Covered California, Medi-Cal, or Other Individual Plan	N/A	N/A	**HCFSA** – You will receive only up to **$500** of the excess Flex Credits, which will be defaulted to this account. You may elect out-of-pocket contributions up to a maximum of $2,550 (resulting in a total combined annual maximum contribution of $3,050).	**DCFSA** – You can elect out-of-pocket contributions, or excess Flex Credits can be designated/ elected to this account, up to $5,000.
Because You Have Group Health Plan Coverage (Non-HDHP)	N/A	All excess Flex Credits will be defaulted to this account, up to a maximum of $5,000.	**HCFSA** – You can elect out-of-pocket contributions up to $2,550. Note: The combination of HRA and HCFSA cannot exceed $5,000. If your FSA election would cause it to exceed the maximum, the FSA would be reduced.	**DCFSA** – You can elect out-of-pocket contributions, or excess Flex Credits can be designated/ elected to this account, up to $5,000.
Because You Have Group Health Plan HDHP Coverage	All excess Flex Credits will be defaulted to this account up to the HSA family limit. Also you may elect out-of-pocket contributions combined with excess Flex Credits up to the limit.	N/A	**Limited/HCFSA** – You may elect out-of-pocket contributions up to $2,550.	**DCFSA** – You can elect out-of-pocket contributions or excess Flex Credits can be designated/ elected to this account, up to $5,000.

	HEALTH SAVINGS ACCOUNT (HSA)	HEALTH REIMBURSEMENT ACCOUNT (HRA)	HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFSA)	DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DCFSA)
IF YOU ELECT COUNTY MEDICAL COVERAGE:				
Under a County Medical Plan (Non-HDHP)	N/A	Excess Flex Credits will be defaulted to this account up to $5,000.	**HCFSA** – You can elect out-of-pocket contributions up to $2,550. Note: The combination of HRA and HCFSA cannot exceed $5,000. If your FSA election would cause it to exceed the maximum, the FSA would be reduced.	**DCFSA** – You can elect out-of-pocket contributions or excess Flex Credits can be designated/ elected to this account, up to $5,000.
Under the HDHP County Medical Plan	All excess Flex Credits will be defaulted to this account up to the HSA limit based on the level of coverage that you elect (employee only or family). Note: You can elect out-of-pocket contributions combined with excess Flex Credits up to the limit.	N/A	**Limited/HCFSA** – You may elect out-of-pocket contributions up to $2,550.	**DCFSA** – You can elect out-of-pocket contributions or excess Flex Credits can be designated/ elected to this account, up to $5,000.

If your excess Flex Credits are less than $120, they will automatically be forfeited.

Employees who want to waive coverage **must** designate their waive status in eBenefits Self Service. In addition, you will need to submit Proof of Health Insurance Coverage through eBenefits.

Pre-Tax Premium Contributions

Medical, Dental, Vision, and supplemental AD&D premiums, as well as contributions to an FSA or HSA, are deducted from your paycheck with pre-tax dollars. This means that contributions are taken from your earnings before federal taxes, Social Security taxes, and, in some cases, state taxes as well, resulting in lower taxes and increased take home pay.

Waiving the County Medical Plan

You may waive medical plan coverage only if:

- You submit a "Proof of Health Insurance Coverage" form and a copy of your insurance card.
- You are covered by another County employee as a spouse or domestic partner and you submit a completed Waiver Form.

Waiving coverage may only be elected during your initial enrollment period, the County's Open Enrollment period or during the year as the result of a qualifying event as defined by Section 125 of the Internal Revenue Code.

2016 Rates

Health Care Coverage

The following shows the per pay period* costs for coverage under County Medical, Dental, and Vision plan options.

PLAN	COVERAGE LEVEL		
	Employee Only	Employee + 1	Employee + 2 or more
MEDICAL			
Kaiser Permanente HMO	$229.98	$459.95	$650.83
Kaiser Permanente HDHP with HSA	$179.53	$359.05	$508.06
Anthem Blue Cross PPO	$553.37	$1,106.73	$1,566.02
Anthem Blue Cross Select HMO	$285.76	$571.44	$808.55
Anthem Blue Cross California Care/ Full Access HMO	$666.27	$1,332.50	$1,885.52
Anthem Blue Cross HDHP with HSA	$432.47	$864.93	$1,223.88
DENTAL			
DeltaCare USA DHMO	$6.84	$12.36	$15.83
Delta Dental PPO	$21.47	$42.93	$61.31
VISION			
VSP Vision Service Plan	$4.45	$10.28	$13.93

*Excluding the third pay periods in the months of July and December.

Supplemental Life Insurance Coverage

Your cost for coverage depends on your age and coverage amount.

Rate per $1,000 of Coverage	AGE (as of August 31, 2015)										
	<35	35 – 39	40 – 44	45 – 49	50 – 54	55 – 59	60 – 64	65 – 69	70 – 74	75 – 79	80>
Monthly	$0.023	$0.033	$0.047	$0.058	$0.092	$0.172	$0.202	$0.446	$1.135	$1.135	$1.135
Per Pay Period*	$0.0115	$0.0165	$0.0235	$0.0290	$0.0460	$0.0860	$0.1010	$0.2230	$0.5675	$0.5675	$0.5675

Supplemental AD&D Coverage

Your cost for coverage depends on your coverage level and amount of your coverage.

COVERAGE LEVEL	MONTHLY (rate per thousand)	PER PAY PERIOD* (rate per thousand)
Employee Only	$0.015	$0.0075
Employee + Family	$0.025	$0.0125

*Excluding the third pay periods in the months of July and December.

Who Is Eligible

You are eligible for benefits if you are:

- An active employee of the County of San Diego who is authorized to work 20 or more hours per week
- An elected official of the County of San Diego

Your Dependents

If you are eligible, you may also enroll your eligible dependents. Eligible dependents include:

- Your legal spouse or domestic partner (same-sex or opposite sex)
- Your children* or your spouse/domestic partner's children* who meet the age requirements (to the left)
- Your children* or your spouse/domestic partner's children* of any age if:
  - They are incapable of self-sustaining employment because of a physical or mental disability that occurred before they reached the age limit for the plan, **and**
  - You provide proof of the child's incapacity and dependency within 60 days after the insurance carrier requests the Disabled Dependent Certification

** Children include your or your spouse/domestic partner's biological children, stepchildren, legally adopted children, children placed with you for adoption, children for whom you have been appointed legal guardian, and children for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) up to the age limit for the plan.*

Child Age Limits

Coverage for dependent children will end at age 26 for the plans in which they are eligible, including:

- Medical
- Dental
- Vision
- Dependent Life
- Supplemental AD&D
- Critical Illness

Dependent Social Security Numbers

We are required to collect the Social Security number and date of birth of any individual(s) enrolled in a County Medical, Dental, and/or Vision plan as the dependent of a benefits-eligible employee. If an employee elects coverage for his or her dependent(s) and does not provide a valid social security number(s) for the dependent(s), the County will not be able to process the enrollment request until the proper information is provided.

Are Your Dependents County Employees?

If you and your spouse or domestic partner are County employees:

- Both County employees are eligible to participate in health care benefits
- Only one of you may be covered as a dependent under the other employee's plan
- Only one of you may cover your eligible dependent children (or grandchildren in the Kaiser HMO or Kaiser HDHP)

Domestic Partners

If you want to enroll your domestic partner:

- Your domestic partner must be at least 18 years of age or older and mentally competent to consent to the domestic partnership.
- You must share a close personal relationship and be responsible for each other's common welfare.
- You must be each other's sole domestic partner.
- You cannot be married to anyone or have another domestic partner within the prior six months.
- You must not be related to each other by blood to a degree that would prohibit legal marriage in the State of California.
- You must share the same regular and permanent residence with the current intent to continue doing so indefinitely.
- You must be mutually financially responsible for each other's "basic living expenses."

How to Enroll Domestic Partners

To enroll a domestic partner, please contact the Benefits Department at 888-550-2203. A Benefits Specialist will assist you with the enrollment process.

Domestic Partners and Health Savings Accounts (HSAs)

If you enroll in an HDHP with HSA plan and you cover a domestic partner under your medical plan, it's important to note that your domestic partner's health care expenses aren't eligible for reimbursement from your Health Savings Account (HSA), unless he or she is considered a federally-recognized spouse or a tax dependent.

However, your domestic partner can set up his or her own HSA to cover his or her eligible expenses. If you both set up HSAs, you can each contribute up to the maximum amount allowed each year by the IRS.

Required Documentation for Coverage

When you enroll in your County benefits, you must provide documentation verifying your or your eligible dependents' eligibility for the change in coverage.

ACTION/CHANGE	REQUIRED DOCUMENTATION (copy of document only; keep the original)
Enroll spouse	• Marriage certificate
Enroll domestic partner	• Registered Domestic Partnership Certification • Affidavit of Domestic Partnership
Enroll dependent child	• Birth certificate • Adoption papers • Custody award papers • Court order requiring you to provide coverage for the child
Electing your Supplemental Life Insurance coverage	• Medical Statement of Health will be mailed to your home address by MetLife.

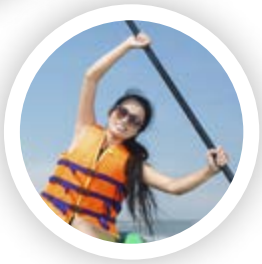
How to Submit Enrollment Documents

Please submit Proof of Other Health Insurance Coverage, Proof of Relationship, Waiver Forms, and Domestic Partner Affidavits through eBenefits. When you are processing your elections in eBenefits, please go to the bottom of the Medical enrollment screen and select "Click Here to Upload Enrollment Documents."

Medical Plans

You have three distinct types of medical plans from which to choose, administered by Anthem Blue Cross or Kaiser Permanente.

Preferred Provider Organization (PPO)	Health Maintenance Organization (HMO)	High Deductible Health Plan with Health Savings Account (HDHP with HSA)
• Anthem Prudent Buyer PPO	• Anthem Select HMO • Anthem California Care/Full Access HMO • Kaiser Permanente HMO	• Anthem HDHP with HSA • Kaiser HDHP with HSA



Preferred Provider Organization (PPO)

The PPO plan allows you to use any provider you want.

Doctors/Health Care Providers: You can choose any doctor you want, and you can go to any hospital or pharmacy. However, you'll pay less when you use a provider or facility that participates in the Anthem PPO network.

Preventive Care: Preventive care is 100% covered when you use in-network providers.

Annual Deductible: You generally pay an annual deductible before the plan begins to pay for a portion of covered medical services. The only services that don't require you to pay a deductible first are preventive care, office visits, and prescription drugs.

Paying for Care: When you receive medical care, there are two ways you pay for services:

- **Copays:** When you go to an in-network doctor for an office visit, go to the emergency room, or pick up a prescription, you pay a set dollar amount called a copay. (You may need to pay the annual deductible first before the copay applies.)
- **Coinsurance:** When you receive any other medical services, you pay a percentage of the cost of the service, and the plan pays the remaining percentage. This is called coinsurance. (You will need to pay the annual deductible first before coinsurance applies.)

Annual Out-of-Pocket Maximum: The PPO includes an out-of-pocket maximum. This is the maximum amount you must pay out of your own pocket (under the applicable coinsurance percentage) after meeting the deductible. Once you reach the out-of-pocket maximum, the plan pays 100% of in-network charges for the remainder of the plan year. Please note that your out-of-pocket maximum will be lower when you use in-network providers.

Health Maintenance Organizations (HMOs)

HMOs allow you to receive comprehensive coverage at set prices, called copays.

Doctors/Other Medical Care Providers: You can only use doctors, hospitals, and pharmacies that participate in the HMO network. Doctors who participate in the HMO network are called in-network providers. There is no coverage if you go to out-of-network providers, except for emergency services.

Annual Deductible: You don't need to pay an annual deductible before the plan begins to pay for a portion of covered medical services.

Copays: When you receive medical care, you pay a set dollar amount called a copay.

Annual Out-of-Pocket Maximum: The HMO plans include an annual out-of-pocket maximum. This is the maximum amount you must pay out of your own pocket for copays during the plan year. Once you reach the out-of-pocket maximum, the plan pays 100% of covered charges for the remainder of the plan year.

Your HMO Options

You can choose from three HMO plan options:

- Anthem Select HMO
- Anthem California Care/Full Access HMO
- Kaiser Permanente HMO

Anthem HMO Plan Participants

If you are currently in the Anthem Select or Anthem Full Access plan, or if you are enrolling for the first time, you need to designate a Primary Care Physician (PCP).

The following steps will assist you with your PCP selection:

1. Visit the Anthem website (**www.anthem.com**) to select a PCP from their Provider Directory.
2. Contact your selected PCP's office and ask if they are accepting new patients.
3. Email **cosdanthem@anthem.com** to elect your PCP. You will need to include the following:
   - Subscribers (employee's) full name
   - Subscribers date of birth
   - HMO Product election (Full Access or Select)
   - Email should include PCP/PMG election for subscriber as well as all enrolled members

High Deductible Health Plans (HDHP) with a Health Savings Account (HSA)

The HDHP with HSA plans are unique medical plans that put you in control of your health care spending. This type of plan has two main components:

1. The medical plan
2. A Health Savings Account (HSA). (See page 16 for details.)

Medical Plan

Doctors/Health Care Providers: The type of provider you can use depends on the plan in which you enroll.

- **Anthem HDHP:** You can choose any doctor you want, and you can go to any hospital or pharmacy. However, you'll pay less when you use a provider or facility that participates in the Anthem PPO network. This is the same network used with the Anthem Prudent Buyer PPO plan.
- **Kaiser Permanente HDHP:** You must use Kaiser Permanente's network of providers. This network is the same network used with the Kaiser Permanente HMO.

Preventive Care: Preventive care is 100% covered. (For the Anthem HDHP, you must use in-network providers.)

Annual Deductible: You pay an annual deductible before the plan begins to pay for a portion of covered medical services. This includes office visits and prescription drugs. The only services that don't require you to pay a deductible first are preventive care.

Coinsurance: When you receive medical services, you pay a percentage of the cost of the service, and the plan pays the remaining percentage. This is called coinsurance. (You will need to pay the annual deductible first before coinsurance applies.)

Annual Out-of-Pocket Maximum: Both the Anthem and Kaiser HDHP plans include an out-of-pocket maximum. This is the maximum amount you must pay out of your own pocket for the annual deductible and coinsurance combined. Once you reach the out-of-pocket maximum, the plan pays 100% of in-network charges for the remainder of the plan year.

Important! Not Everyone Can Open an HSA

All employees are eligible to enroll in an HDHP with HSA plan. However, you may not be eligible to open an HSA. Individuals who are not eligible to open an HSA include:

- Those who are enrolled in Medicare (remember, enrolling in Social Security Income or SSI — the income portion of Social Security — automatically enrolls you in Medicare Part A)
- Those who are receiving health benefits under TRICARE
- Those who have received Veteran Administration (VA) benefits within the past 3 months
- Those who are covered by another non-qualified high deductible health plan (such as a spouse's plan)
- Those who can be claimed as a dependent on another individual's tax return
- Those who are considered active military
- Those who have a balance in an FSA account

Health Savings Account

For both of the HDHP with HSA plans, you can contribute to a Health Savings Account (HSA). The HSA is a key part of the HDHP plans and allows you to save toward out-of-pocket expenses now and in the future. You can use HSA funds for any IRS qualified Medical, Dental, and Vision expenses.

In 2016, here's how much you can contribute to an HSA:

- Employee only coverage: $3,350
- Employee + 1 or more coverage: $6,750

The County may also contribute to your HSA if you have excess Flex Credits. If you enroll for an HDHP with HSA plan, any excess Flex Credits are automatically placed in your HSA. The limits above include both contributions from you and the County.

The HSA is not established or administered by the County — you must set up your HSA. If you want to contribute to your HSA through payroll deductions, you must set up your HSA through Wells Fargo Bank.

How to Set Up Your HSA/How to Use Your HSA

Setting up and using your HSA is easy. Follow the steps below to get started.

Step 1

Enroll in an HDHP with HSA plan, and choose to set up an HSA to help pay for your eligible expenses (e.g., deductible, coinsurance, prescriptions).

Step 2

Sign the authorization form so the County can help set up an HSA for you at Wells Fargo.

Step 3

Review the Welcome Kit from Wells Fargo that you will receive at your home. This kit includes details of the HSA account, where to find a list of qualified expenses, and any potential fees associated with the account. Please fill out the forms and return them to Wells Fargo.

Step 4

Use your HSA debit card at the point of sale or when receiving services, for example at a doctor's office to pay the visit fee or the pharmacy to pay for a prescription. You can also use the debit card to withdraw money to reimburse yourself at any Wells Fargo ATM. (Keep in mind — the money must be in your HSA for you to withdraw it.)

Step 5

Save your receipts. If you are audited, you must provide proof that you have used the funds in your HSA according to IRS guidelines.

Questions?
Go to **www.wellsfargo.com\hsa**

HDHP Plans and the HSA: How They Work Together

Health Savings Account (HSA)
Your contributions to the Health Savings Account can cover your deductible and coinsurance

Preventive Care	Deductible	Coinsurance	Out-of-Pocket Maximum
The plan pays 100%.	You pay 100%. Once you meet the deductible, coinsurance kicks in.	You and the plan share a percentage of the cost until you meet the out-of-pocket maximum.	Once you reach this, the plan pays 100% of in-network costs.

Prescription Drug Benefits

When you enroll for a medical plan, you will automatically receive prescription drug coverage.

- **Anthem Blue Cross PPO, HMO, and HDHP with HSA plans:** The pharmacy benefits manager is Anthem. You will receive one combined ID card for medical and prescription drug benefits.
- **Kaiser HMO and HDHP plans:** Your medical plan ID card is valid for both medical and prescription drug coverage. Kaiser hospitals and medical facilities have Kaiser pharmacies on site.

Complete information on the Anthem and Kaiser Permanente prescription drug coverage is available on the County of San Diego's intranet at the Department of Human Resources — Benefits section.

Ask About Generics

If you need medication, ask your doctor if the prescription can be filled with a generic brand. Why pay more if you don't have to? The Food and Drug Administration requires that generic drugs have the same active chemical composition, have the same strength, and be offered in the same dosage form as their brand-name counterparts. Competitive pricing by the different generic drug manufacturers keeps the prices down, which means generic drugs cost a lot less. And those savings can really add up over the year!

Medical Plans at a Glance

The following charts provide a comparison of costs and benefits for the County of San Diego medical plans.

	ANTHEM PRUDENT BUYER PPO		ANTHEM SELECT HMO	ANTHEM CALIFORNIA CARE/ FULL ACCESS HMO	ANTHEM HDHP WITH HSA	
	In-Network	**Out-of-Network**	**In-Network Only**	**In-Network Only**	**In-Network**	**Out-of-Network**
Network	PPO		Select	California Care/Full Access	PPO	
Annual Deductible						
• Individual	$300	$600	None	None	$1,500	$3,000
• Employee + 1	$600	$1,200			$3,000	$6,000
• Employee + 2	$600	$1,200			$3,000	$6,000
Out-of-Pocket Maximum						
• Individual	$2,000	$4,000	$2,000	$2,000	$3,000	$9,000
• Employee + 1	$4,000	$8,000	$4,000	$4,000	$6,000	$18,000
• Employee + 2	$4,000	$8,000	$6,000	$6,000	$6,000	$18,000
OUTPATIENT SERVICES						
Preventive Care	$0	40%[1, 2] (adult physical exams not covered)	$0	$0	$0	30%[1]
Office Visits						
• Primary Care	$20 copay	40%[1]	$25 copay	$30 copay	10%[1]	30%[1]
• Specialist	$40 copay	40%[1]	$40 copay	$45 copay	10%[1]	30%[1]
Acupuncture	20%[1, 2]	40%[1, 2]	$25 copay	$30 copay	10%[1]	30%[1]
Home Health Care	20%[1, 2]	40%[1, 2]	$0[2]	$0[2]	10%[1]	30%[1]
Physical, Occupational, Speech Therapy	20%[1, 2]	40%[1, 2]	$0[2] outpatient; $25 copay in facility	$0[2] outpatient; $30 copay in facility	10%[1]	30%[1]
Chiropractic	20%[1, 2]	40%[1, 2]	$25 copay	$30 copay	10%[1]	30%[1]
Diagnostic X-Ray and Lab	20%[1]	40%[1]	$0	$0	10%[1]	30%[1]
Specialty X-Rays (CT, MRI, PET, CAT)	20%[1, 2]	40%[1, 2]	$100 copay	$100 copay	10%[1]	30%[1]
Durable Medical Equipment	20%[1, 2]	40%[1, 2]	$0	$0	50%[1]	50%[1]
HOSPITAL SERVICES						
Inpatient (per admission)	20%[1]	40%[1]	$200 copay	$200 copay	10%[1]	30%[1]
Outpatient Facility	20%[1]	40%[1]	$100 copay	$100 copay	10%[1]	30%[1]
EMERGENCY SERVICES						
Emergency Room (applicable copay waived if admitted)	$75 copay + 20%[1]	$75 copay + 20%[1]	$125 copay	$125 copay	10%[1]	10%[1]
Urgent Care Facility	20%[1]	40%[1]	$40 copay	$45 copay	10%[1]	30%[1]
Ambulance	20%[1]	40%[1]	$0	$0	10%[1]	30%[1]
MENTAL HEALTH/SUBSTANCE ABUSE						
Inpatient	$150 per admission, 20%[1]	$300 per admission, 40%[1]	$200 per admission	$200 per admission	10%[1]	30%[1]
Outpatient Physician Visits (18 and over)	$20 copay[2]	40%[1]	$25 copay [2]	$30 copay [2]	10%[1]	30%[1]
PRESCRIPTION DRUGS						
Retail Pharmacy (30-day supply)						
Generic	$10 copay	$10 copay	$10 copay	$10 copay	$10[1]	Copay plus all charges over the maximum allowed amount[1]
Brand Formulary	$20 copay	$20 copay	$20 copay	$20 copay	$30[1]	
Brand Non-formulary	$35 copay	$35 copay	$35 copay	$35 copay	$50[1]	
Mail Order (90-day supply)						
Generic	$20 copay	$20 copay	$20 copay	$20 copay	$10[1]	Copay plus all charges over the maximum allowed amount[1]
Brand Formulary	$40 copay	$40 copay	$40 copay	$40 copay	$60[1]	
Brand Non-formulary	$60 copay	$60 copay	$60 copay	$60 copay	$100[1]	

1 You must meet the deductible first before coinsurance or copays apply.
2 Limits, exclusions, or utilization review apply. See plan documents for details.
3 Copay waived for emergency admission.

This chart is a summary of general benefits available to County of San Diego eligible employees. Wherever conflicts occur between the contents of this chart and the plan terms, then the evidence of coverage (EOC) plan document will prevail. Space does not permit listing all limitations and exclusions that apply to each plan. Before using your benefits, call the plan for information.

	KAISER PERMANENTE HMO	KAISER PERMANENTE HDHP WITH HSA
Network	Kaiser	Kaiser
Annual Deductible • Individual • Employee + 1 • Employee + 2	None	 $1,500 $3,000 $3,000
Out-of-Pocket Maximum • Individual • Employee + 1 • Employee + 2	 $1,500 $3,000 $3,000	 $3,000 $6,000 $6,000
OUTPATIENT SERVICES		
Preventive Care	$0	$0
Office Visits • Primary Care • Specialist	 $25 copay $25 copay	 10%[1] 10%[1]
Acupuncture	Not covered	Not covered
Home Health Care	$0[2]	$0 (up to 100 visits)[1, 2]
Physical, Occupational, Speech Therapy	$25 copay	10%[1]
Chiropractic	Not covered	Not covered
Diagnostic X-Ray and Lab	$0	10%[1]
Specialty X-Rays (CT, MRI, PET, CAT)	$0	10%[1]
Durable Medical Equipment	$0[2]	10%[1]
HOSPITAL SERVICES		
Inpatient (per admission)	$100 copay	10%[1]
Outpatient Facility	$25 copay per procedure	10%[1]
EMERGENCY SERVICES		
Emergency Room (waived if admitted)	$125 copay	10%[1]
Urgent Care Facility	$25 copay	10%[1]
Ambulance	$0	10%[1]
MENTAL HEALTH/SUBSTANCE ABUSE		
Inpatient (per admission)	$100 copay	10%[1]
Outpatient Physician Visits (18 and over)	$25 copay individual; $12 copay group	10%[1]
PRESCRIPTION DRUGS		
Retail Pharmacy		
Generic	Up to 30 days: $10 copay 31 to 60 days: $20 copay 61 to 100 days: $30 copay	Up to 30 days: $10 copay[1] 31 to 60 days: $20 copay[1] 61 to 100 days: $30 copay[1]
Brand Formulary	Up to 30 days: $25 copay 31 to 60 days: $50 copay 61 to 100 days: $75 copay	Up to 30 days: $30 copay[1] 31 to 60 days: $60 copay[1] 61 to 100 days: $90 copay[1]
Brand Non-formulary	Not covered; if prescribed by KP physician, $25 copay for up to 30-day supply	Not covered; if prescribed by KP physician, $25 copay for up to 30-day supply
Mail Order		
Generic	Up to 30 days: $10 copay 31 to 100 days: $20 copay	Up to 30 days: $10 copay[1] 31 to 100 days: $20 copay[1]
Brand Formulary	Up to 30 days: $25 copay 31 to 100 days: $50 copay	Up to 30 days: $30 copay[1] 31 to 100 days: $60 copay[1]
Brand Non-formulary	Not covered	Not covered

1 You must meet the deductible first before coinsurance or copay applies.
2 Limits, exclusions, or utilization review apply.

This chart is a summary of general benefits available to County of San Diego eligible employees. Wherever conflicts occur between the contents of this chart and the plan terms, then the evidence of coverage (EOC) plan document will prevail. Space does not permit listing all limitations and exclusions that apply to each plan. Before using your benefits, call the plan for information.

Important Notes About Your Dental Plans

- Neither plan will cover crowns, inlays, onlays, posts and cores, dentures, or orthodontic services prescribed before your plan coverage becomes effective.
- Some major services require pre-authorization in order to be covered. It's a good idea to submit a plan for any major work to the dental plan for a "pre-determination of benefits," which will let you and your dentist know how much the plan will pay.
- If you and your dependents are covered under two dental plans at the same time, coordination of coverage rules apply. "Coordination of coverage" determines which plan should pay first and which plan would pay second. The general rule is that the plan that covers you as an enrollee is the primary plan and the plan which covers you as a dependent is the secondary plan. If the County of San Diego's dental plan is considered the secondary plan, the County of San Diego plan will not pay for any out-of-pocket expenses required under the primary plan.

Dental Plans

You have two dental plans to choose from, both administered by Delta Dental.

Delta Dental PPO/Premier Plan

The Delta Dental PPO/Premier plan allows you to use any provider you want.

Dentists/Other Dental Care Providers: You can choose any dentist you want. However, you'll pay less when you use a provider or facility that participates in the Delta Dental PPO/Premier network. **If you access the Premier network and the dentist is not also in the PPO network, you'll still benefit from receiving the network charge and avoiding being balance billed.**

Preventive Care: Preventive care is 100% covered when you use in-network providers.

Annual Deductible: You generally pay an annual deductible before the plan begins to pay for a portion of covered basic and major services. The deductible does not apply to preventive care.

Coinsurance: When you receive any other dental services, you pay a percentage of the cost of the service, and the plan pays the remaining percentage. This is called coinsurance. (You will need to pay the annual deductible first before coinsurance applies.)

Annual Maximum Benefit: The Delta Dental PPO/Premier plan includes an annual benefit maximum. This is the maximum amount the plan will pay for your dental services each year. Once you reach the annual benefit maximum, you will pay the full cost of any future dental services for that year.

DeltaCare USA DHMO Plan

The DHMO plan allows you to receive comprehensive coverage at set prices, called copays.

Dentists/Other Dental Care Specialists: You can only use dentists who participate in the DeltaCare USA DHMO network. Dentists who participate in the DeltaCare USA DHMO network are called in-network dentists. There is no coverage if you go to out-of-network dentists.

Annual Deductible: You don't need to pay an annual deductible before the plan begins to pay for a portion of covered dental services.

Copays: When you receive dental care, you pay a set dollar amount called a copay.

DeltaCare USA DHMO Participants

If you are enrolling in the DeltaCare USA DHMO plan for the first time, you need to designate a Primary Care Dentist (PCD).

The following steps will assist you with your PCD selection:

1. Visit the Delta website (**www.deltadentalins.com**) to select a PCP from their Provider Directory.
2. Contact your selected PCD's office and ask if they are accepting new patients.

Dental Plans at a Glance

The following charts provide a comparison of costs and benefits for the County of San Diego dental plans.

	DELTA DENTAL PPO		DELTACARE USA DHMO
PLAN FEATURES			
Network of Dental Providers	Delta Dental PPO dental in-network or out-of-network		DeltaCare USA DHMO dental in-network only
Annual Deductible • Individual • Family Maximum	 $50 $150		Not applicable
Annual Maximum Benefit	$2,000 per person		None
PLAN BENEFITS			
	In-Network	**Out-of-Network**	
Preventive Care[1] (Checkups, cleaning, X-rays, sealants, fluoride treatments, space maintainers)	$0; no deductible required	20% after deductible	100% covered for most services, small copay for sealants and space maintainers
Basic Services (Fillings, simple extractions, root canal, periodontics, etc.)	20% after deductible	20% after deductible	Copays vary — see Schedule of Benefits
Major Services[1, 2] (Crowns, dentures, denture reline, fixed bridge)	30% after deductible	40% after deductible	Copays vary — see Schedule of Benefits
Orthodontia (24-month banding for children and adults)	You MUST use a the DeltaCare USA Orthodontic Network. You pay $1,695 plus all charges incurred before banding begins and after banding removal. Contact Delta Dental at 877-688-3503 for a referral form. To access the DHMO orthodontic network, you must first contact DeltaCare USA at 844-697-0579 and request a referral form.		

1 Frequency of some items is limited. Check plan documents for details.
2 Check plan documents for plan limitations on some services.

This chart is a summary of general benefits available to County of San Diego eligible employees. Wherever conflicts occur between the contents of this chart and the plan terms, then the evidence of coverage (EOC) plan document will prevail. Space does not permit listing all limitations and exclusions that apply to each plan. Before using your benefits, call the plan for information.

Vision Plan

The County of San Diego offers you vision coverage through Vision Service Plan (VSP). The plan features include:

- **Eye Doctors:** You can choose any vision provider you want. However, you pay more when you use a vision provider who does not participate in the VSP network. Eye doctors who participate in the VSP network are called in-network providers; those who don't participate in the network are considered out-of-network.
- **Paying for Care:** When you receive vision care, the amount you pay depends on what type of eye doctor you use:
  - **In-network eye doctors:** When you receive vision care, you generally pay a set dollar amount called a copay. For frames and elective contact lenses, the plan will pay up to an allowance amount, and you pay the full cost over this allowance.
  - **Out-of-network eye doctors:** When you receive vision care, the plan will pay up to an allowance amount. You pay the full cost of services over this allowance.

Vision Benefits at a Glance

You can select vision care coverage through Vision Service Plan (VSP). Plan features and costs are highlighted below. You will save money when you use in-network providers.

	IN-NETWORK	OUT-OF-NETWORK
PLAN FEATURES		
Network	Any provider in the VSP network. You'll save money when you stay in-network.	Any provider you wish.
Copay	$15 per person	$15 per person
PLAN BENEFITS		
Eye Exams (once per plan year)	Plan pays 100%	Plan pays 100%, up to $40
Lenses (one pair per plan year) Single vision, bifocal, trifocal, or lenticular; glass or plastic	Plan pays 100% after deductible	Plan pays 100%, up to the following amounts. You pay all charges over these amounts: Single vision: Up to $40 Bifocal: Up to $60 Trifocal: Up to $80 Lenticular: Up to $125
Frames (once every 24 months)	Plan pays 100% after deductible, up to $130; then, you pay all charges over $130	Plan pays 100%, up to $45, after deductible; then, you pay all charges over $45
Contact Lenses (once a year)		
• Cosmetic	Plan pays 100% after deductible, up to $105; then, you pay all charges over $105	Plan pays 100% after deductible, up to $105; then, you pay all charges over $105
• Medically necessary	Plan pays 100% after deductible	Plan pays 100% after deductible, up to $210; then, you pay all charges over $210
Laser Eye Surgery	Plan pays up to $500 per eye *VSP contracts with participating laser vision correction facilities to provide discounts to VSP members. The discounted price will not exceed $1,800 per eye for LASIK, $1,500 per eye for PRK, and $2,300 per eye for Custom LASIK. In the event that you receive laser vision correction services on one eye only, any remaining balance may not be applied towards the cost of surgery in the second eye.*	

Employee Assistance Program

The Employee Assistance Program (EAP) is a confidential service available to employees, their household members, and their eligible dependents — at no cost to you! Anthem EAP's trained professionals can easily refer you to the following resources:

Face-to-Face Counseling

Anthem EAP can put you in touch with a licensed counselor for eight face-to-face visits. You and your household members are eligible for up to eight visits for each personal situation, as needed. If more than eight sessions are needed, employees are referred to the health insurance company for potential health benefits or to community resources for on-going care.

Crisis Counseling

24/7 telephone access and crisis consultation are available to you through Anthem EAP. If you have an emergency, simply call the toll-free Anthem EAP phone number. They will put you in touch with a professional who can help or just listen, depending on your needs.

Legal Assistance

Anthem EAP also offers access to legal consultations up to 30 minutes face to face or by telephone at no charge. For services beyond the initial 30 minutes, you will receive a preferred discount rate of 25% off an attorney's normal hourly fee. You have access to virtually all areas of law such as family/domestic matters, civil matters, criminal, real estate, etc. Matters involving disputes between employees and the County are specifically excluded from eligibility for this program.

Tobacco Cessation (Online and Coaching)

- **Online Program:** LivingFree™ is a free online program to help you learn how to break the tobacco use habit. The program focuses on the emotional and physical causes of tobacco use.
- **Coaching by Phone:** Tobacco cessation coaching is a free service provided by phone or through instant messaging. Your coach will help you address the triggers of your tobacco use and how to overcome them. In addition, your coach can address issues related to weight management and fitness.

Dependent Care and Daily Living Resources

You and your household members can get information on child care, adoption, summer camps, college placement relocation, and resources on elder care and assisted living. In addition, you can receive assistance with daily living issues such as house-hold maintenance, moving, pet care, etc. Referrals are available through the Assisted Search feature on the Anthem EAP website (**www.AnthemEAP.com**) or by calling toll-free at 888-777-6665.

Other Online Resources

Informational articles on behavioral health and health care topics are available for you and your household members through Anthem EAP's interactive website at **www.AnthemEAP.com**. There are self-assessment tools and quizzes on topics such as health, depression, and substance abuse. Legal information and financial calculators are also available.

Contact the EAP

- By phone: 888-777-6665
- Online: **www.AnthemEAP.com**

Flexible Spending Accounts (FSAs)

Flexible Spending Accounts (FSAs) provide you with a way to pay for eligible out-of-pocket health care and dependent day care expenses.

The County of San Diego offers three FSAs through ASIFLEX:

- Health Care FSA
- Limited Purpose Health Care FSA (for those who participate in an HDHP with HSA plan)
- Dependent Care FSA

When you participate in an FSA, you decide how much you want to contribute each plan year, up to the IRS limits. The money you contribute is then deducted from your pay before taxes are withheld — this lowers your taxable income, which means lower taxes for you!

How FSAs Work

FSAs are a great way to save money on your eligible health care and dependent care expenses, and they're easy to use. Here's how they work:

- **Decide how much to contribute:** Decide how much you want to contribute to your FSA during the benefit plan year (January 1 through December 31). Throughout the year, your election is deducted in equal amounts from your paycheck before taxes are taken out.
- **Be sure to estimate carefully:** Any money over $500 you don't use during the plan year will be forfeited due to IRS regulations. (This is called the "use it or lose it" rule.) If you elect an HSA for the following plan year, any carryover money will be directed into a Limited Purpose FSA (dental and vision purposes only).
- **Pay your expenses and file claims:** When you pay for eligible expenses, save your receipts. Then, file a claim for reimbursement. You have until March 31 to file claims for the previous plan year.
- **Receive tax-free reimbursement:** Once your claim is approved, you'll receive reimbursement by check or funds will be direct deposited into your account.

Important!

If you want to participate in an FSA, you must enroll every year.

Health Care FSA

You may generally contribute from $120 to $2,550 per year to the Health Care FSA to pay for out-of-pocket health care expenses for you and your dependents.

Eligible expenses include:

- Deductibles
- Copays
- Coinsurance
- Some health care items aren't covered by a plan such as hearing aids
- Over-the-counter drugs when prescribed by a doctor

For a compete list of eligible expenses, visit **www.asiflex.com/sdcounty**.

Keep in mind: If you do not spend all of the money in your Health Care FSA, you can roll over up to $500 into the next plan year, unless you elect an HSA for the next plan year. The rollover amount will not count toward your maximum contribution for the following plan year, in addition to your annual contribution.

Limited Purpose Health Care FSA

The Limited Purpose Health Care FSA is available for employees who enroll in the HDHP with HSA medical plan. You may contribute from $120 to $2,550 per year to pay for non-medical expenses, like dental and vision care.

Dependent Care FSA (DCFSA)

With the Dependent Care FSA, you can pay for eligible out-of-pocket day care expenses you have so that you can work. Eligible dependents include children under age 13 and adult dependents who are identified as dependents on your income tax return and who live with you at least eight hours per day. Eligible expenses include:

- Daycare (provided by someone who is not your spouse or child under age 19)
- Babysitting
- Day camps
- Before and after school care programs.

You may contribute from $120 to $5,000 per year to the Dependent Care FSA. However, if you are married and you and your spouse file separate federal income tax returns, the most you can contribute to a Dependent Care FSA is $2,500.

Your Participation in a DCFSA during a Leave of Absence

You contributions will automatically continue as long as you continue to receive pay and/or your excess Flex Credits are directed to this account. Although you will continue to contribute to your Dependent Care FSA during a leave of absence, dependent care expenses that you incur during the leave will not be eligible for reimbursement due to IRS rules.

Plan Your FSA Contributions Carefully

The IRS has several rules about FSAs that require you to plan carefully:

- Expenses must be incurred between January 1 and December 31 of the year for which you're making contributions.
- Health Care FSA balances up to $500 will rollover to your account for the following year. The rollover will take place as long as you are an active employee. Any FSA balances over $500 at the end of the year will be forfeited.
- If you enroll in an HSA for the following plan year, any carryover funds will be directed into a Limited Purpose FSA (dental and vision purposes only).
- You can reimburse health care expenses only through the Health Care FSA; you can reimburse dependent day care expenses only through the Dependent Care FSA.
- You cannot change your FSA contributions during the year unless you have a qualifying event (see page 5).

Health Reimbursement Accounts (HRA)

An HRA works like an FSA, except, due to regulations, employees are unable to have both an HRA and make contributions to an HSA. You are also unable to have a balance in a Health Care FSA and open an HSA.

The HRAs will be administered by the County's FSA administrator and have similar eligible expenses as an FSA, including a combined rollover total of $500 between the FSA and the HRA.

Your excess Flex Credits can be directed into an account, based on the plan in which you are enrolled (see pages 6 and 7 for details).

Enrolling in an HDHP with HSA?

If you're in an HDHP with HSA medical plan, you are **not** eligible to contribute to a Health Care FSA. Instead, you can open a Health Savings Account (HSA) to pay for eligible expenses tax-free and, if you wish, a Limited Purpose Health Care FSA.

Spending Account Comparison

Review the table below for a high-level comparison of all of the spending accounts available to you.

	HEALTH CARE FSA	LIMITED PURPOSE FSA	DEPENDENT CARE ACCOUNT	HSA	HRA
Eligibility	All; except those contributing to an HSA account	Must be covered under a qualified high deductible health plan	All	Must be covered under a qualified high deductible health plan	Those enrolled in a Group Medical Plan
Account Owner	Employer	Employer	Employer	Employee	Employer
Who Funds	Employee or Employer	Employee or Employer	Employee or Employer	Employee or Employer	Employer
Annual Contribution Maximums	Employee up to $2,550; employer up to $500	Employee up to $2,550; employer up to $500	$5,000 per calendar year; $2,500 per calendar year if married and filing separate tax returns	$3,350 (individual); $6,750 (family)	Up to $5,000
Eligible Expenses	Code 213(d) medical expenses of employee, spouse, children under age 26, and dependents, incurred during the coverage period	Dental, vision expenses not covered by insurance or under any other source	Child or adult care that is work-related and for the protection and well-being of the dependent	Code §213(d) medical expenses of employee, spouse, children under age 26, and dependents, incurred during the coverage period	Code §213(d) medical expenses of employee, spouse, children under age 26, and dependents, incurred during the coverage period
Proof of Payment Required	Yes	Yes	Yes	Yes (HSA account holder must retain records)	Yes
Carries Over Year to Year	Participant can carry over up to $500 into following plan year	Participant can carry over up to $500 into following plan year combined with HRA	Participant cannot carry over any remaining balance into the following plan year	Yes	Up to $500 combined with any FSA rollover funds
County Comments	Employees will continue to have the option to contribute to a Health Care FSA	Employees with an HDHP will continue to have the option to contribute to a Limited Purpose FSA	Employees will continue to have the option to contribute to a Dependent Care FSA	Employees enrolled in an HDHP will have excess Flex Credits contributed to an HSA and employees can also contribute to HSA accounts (subject to contribution maximums)	Employees not enrolled in an HDHP or a Dependent Care FSA and who are enrolled in a group medical plan will have excess Flex Credits contributed to an HRA. The HRA account structure and rules will mimic the current FSA structure

Life Insurance

Life insurance is administered by MetLife and provides a financial benefit for your beneficiaries in the case of your death. The County of San Diego automatically provides you with a basic amount. You may choose to purchase additional coverage.

Basic Life Insurance

The County provides basic Life Insurance coverage for you at no cost to you. The amount depends on your job classification.

In addition, the County provides $2,000 of Life Insurance coverage for your:

- Spouse
- Registered domestic partner
- Each dependent child, up to age 26.

Supplemental Life Insurance

You may choose to purchase additional Life Insurance coverage for yourself. Coverage is available in amounts equal to one, two, or three times your annual salary, up to a maximum of $1,000,000 of coverage with the submission of a Medical Statement of Health.

The Medical Statement of Health is "proof of good health" and certifies that you're generally healthy at the time of purchasing coverage. If you elect or increase Supplemental Life Insurance, you will need to complete a Medical Statement of Health. The Medical Statement of Health will be mailed by MetLife directly to your home address. Please know that final approval comes from MetLife.

Your coverage will become effective only after the insurance company has approved your Medical Statement of Health if you elect life insurance coverage during your initial enrollment period.

Designate a Beneficiary … and Keep the Name Up to Date

Your designated beneficiary is the person or persons who will receive your Life and AD&D insurance benefits if you should die.

It's important to designate a beneficiary when you first enroll.

Life can bring changes, so it's also important to check your beneficiary designation each year to make sure your beneficiary is still accurate. Please note that if you do not designate a beneficiary, your benefit will be paid to your estate.

For Couples Who Are Both County Employees

- If you and your spouse/domestic partner are both County employees, each of you will receive employee basic Life Insurance. The County will not provide coverage for either of you as a dependent.
- For your children, the County will provide $2,000 of coverage assigned to one of you — but not to both of you.

Accidental Death & Dismemberment (AD&D) Insurance

AD&D insurance, administered by MetLife, provides a financial benefit for you or your beneficiaries in the case of your accidental death or covered injury.

The County provides basic AD&D insurance for you at no cost to you. The amount of coverage is equal to your basic Life Insurance coverage, based on your job classification.

If an accident causes your death, your beneficiary will receive your basic and any supplemental Life and AD&D coverage amounts. If an accident causes you to lose one or more limbs or senses, you will receive all or part of your basic and supplemental AD&D coverage amount. If a dependent dies while covered by the AD&D insurance plan, you are the beneficiary.

Supplemental AD&D Coverage

You may purchase supplemental AD&D coverage for yourself or for your eligible dependents:

COVERAGE	COVERAGE AMOUNT
For You	1, 2, or 3 times your annual salary, up to $1,000,000
For Your Spouse/ Domestic Partner Only	60% of your supplemental AD&D coverage amount
For Your Dependent Children Only	25% of your supplemental AD&D coverage amount per child, up to $50,000 per child
For Your Spouse/ Domestic Partner and Dependent Children	Spouse/domestic partner: 50% of your supplemental AD&D coverage amount Dependent children: 15% of your supplemental AD&D coverage amount per child, up to $50,000 per child

Voluntary Benefit Plans

If you're physically healthy, you can work, play, take care of your family, and enjoy life. But, if something were to happen to you, all your hard work — and everything you have — could be lost unless you take steps to protect your income.

Having adequate insurance coverage is not only the basis for a sound financial blueprint, it helps to provide the protection you need to ensure that your family, your home, and your finances will be protected.

The voluntary insurance options available through the County are offered at a special discounted group rate, which you pay through payroll deductions if you elect coverage.

Voluntary Short-Term Disability Insurance (STD)

When a non-work related illness or injury makes it impossible for you to work for a short period of time, STD guards you against financial loss.

There are two new voluntary Short-Term Disability plans offered to County employees. The plans are designed separately for employees who currently pay into the State Disability Insurance Tax (SDI) through their paycheck, and for those who do not pay this tax. Please note that all leave balances must be exhausted prior to the benefit being paid. For more details please refer to the table below:

SHORT-TERM DISABILITY INSURANCE		
	STD for CA/SDI Participants	STD for non-CA/SDI Participants
Benefit Waiting Period	14 days	7 days
Weekly Maximum Benefit	25% to $1,000	60% to $1,500
Weekly Minimum Benefit	$100 per week	$100 per week
Maximum Benefit Duration	24 weeks	3, 7, or 12 weeks
Plan Limitations	Leave accruals and Social Security pay first	Leave accruals and Social Security pay first. All leave balances must be exhausted prior to the benefit being paid.

Coverage is offered through Cigna and is provided as an a post-tax deduction, which is an advantage to you since any benefits paid to you will be tax-free.

2016 Rates for Coverage

The cost of this insurance program is paid by you. The per pay period* cost per $10 of weekly covered benefit is shown below.

Rates for CA/SDI Participants:

AGE	COST PER $10 OF WEEKLY COVERED BENEFIT
<50	$0.31
50 – 54	$0.31
55 – 59	$0.345
60 – 64	$0.405
65 – 69	$0.44

*Excluding the third pay periods in the months of July and December.

Rates for **NON**-CA/SDI Participants:

AGE	RATE PER $10 OF WEEKLY COVERED BENEFIT 3 – WEEK DURATION (OPTION 1)	RATE PER $10 OF WEEKLY COVERED BENEFIT 7 – WEEK DURATION (OPTION 2)	RATE PER $10 OF WEEKLY COVERED BENEFIT 12 – WEEK DURATION (OPTION 3)
<50	$0.229	$0.3745	$0.4345
50 – 54	$0.229	$0.3745	$0.4345
55 – 59	$0.2545	$0.4165	$0.4825
60 – 64	$0.296	$0.4855	$0.562
65 – 69	$0.326	$.5325	$0.6165

Designate a Beneficiary … and Keep the Name Up to Date

It's important to designate a beneficiary when you first enroll.

Please follow the instructions in the Welcome Letter you receive at your home from Allstate to log on to the "My Benefits" website. There you can view information regarding your policy, file claims, and download your Beneficiary Form for submission to Allstate.

Life can bring changes, so it's also important to check your beneficiary designation each year to make sure your beneficiary is still accurate. Please note that if you do not designate a beneficiary, your benefit will be paid to your estate.

Voluntary Long-Term Disability Insurance (LTD)

This plan pays Long-Term Disability benefits monthly to replace a portion of your income until you are able to return to work, as shown below. Please note that all leave balances must be exhausted prior to the benefit being paid. You are eligible for this plan if you do not currently have Long-Term Disability coverage through MetLife.

LONG-TERM DISABILITY INSURANCE	
Benefit Waiting Period	180 days
Monthly Benefit	60% to $5,000
Monthly Minimum Benefit	$100
Maximum Benefit Duration	Social security normal retirement age
Plan Limitations	Leave accruals and Social Security pay first. All leave balances must be exhausted prior to the benefit being paid.

Please see your Summary Plan Description for a complete description of plan provisions, exclusions and limitations for the plan.

2016 Rates for Coverage

The cost of this insurance program is paid by you. The per pay period* cost per $100 of monthly covered earnings are shown below.

AGE	RATE PER $100 OF MONTHLY COVERED PAYROLL
<20	$0.035
20 – 24	$0.035
25 – 29	$0.045
30 – 34	$0.0865
35 – 39	$0.135
40 – 44	$0.202
45 – 49	$0.272
50 – 54	$0.3765
55 – 59	$0.3995
60 – 64	$0.4215
65 – 69	$0.438
70+	$0.449

*Excluding the third pay periods in the months of July and December

Critical Illness Insurance

Critical Illness Insurance is being offered by Allstate Insurance Company. The Critical Illness Plan pays a cash benefit to you for any of a comprehensive list of serious illnesses, including cancer, heart attack, stroke and more.

You are eligible to cover yourself, your spouse, and your children under this plan. You can elect coverage in three different levels.

CRITICAL ILLNESS		
Benefit Amounts	Employee: $10,000, $20,000, or $30,000 Spouse & children: 50% of employee elected amount	
Benefit Triggers (100%)	Invasive cancer Coma Heart attack End stage renal failure Major organ transplant	Benign brain tumor Complete blindness Complete loss of hearing Paralysis Stroke
Benefit Triggers (25%)	Coronary artery bypass surgery Transient ischemic attack	Carcinoma in situ
Pre-Existing Condition Clause	Waived	
Wellness Benefit	$100 annually	
Second Event Benefit	100% with 12-month separation of diagnoses – or treatment-free	

Please know by enrolling in this plan you are confirming you currently have comprehensive health benefits from either an insurance policy or an HMO.

2016 Rates for Coverage

The cost of this insurance program is paid by you. The per pay period* costs are shown below.

$10,000 POLICY**		
Ages	EE, EE+CH	EE+SP, FAM
18 – 24	$ 3.64	$ 6.84
25 – 29	$ 4.10	$ 7.53
30 – 34	$ 4.74	$ 8.50
35 – 39	$ 5.39	$ 9.46
40 – 44	$ 6.67	$ 11.38
45 – 49	$ 8.37	$ 13.94
50 – 54	$ 10.33	$ 16.87
55 – 59	$ 13.56	$ 21.72
60 – 64	$ 19.86	$ 31.18
65 – 69	$ 28.77	$ 44.54
70 – 74	$ 34.02	$ 52.40
75 – 79	$ 39.62	$ 60.81
80+	$ 48.87	$ 74.68

$20,000 POLICY**		
Ages	EE, EE+CH	EE+SP, FAM
18 – 24	$ 4.53	$ 8.17
25 – 29	$ 5.44	$ 9.54
30 – 34	$ 6.73	$ 11.47
35 – 39	$ 8.03	$ 13.42
40 – 44	$ 10.58	$ 17.25
45 – 49	$ 14.00	$ 22.37
50 – 54	$ 17.90	$ 28.23
55 – 59	$ 24.36	$ 37.92
60 – 64	$ 36.97	$ 56.83
65 – 69	$ 54.79	$ 83.56
70 – 74	$ 65.28	$ 99.29
75 – 79	$ 76.48	$ 116.10
80+	$ 94.97	$ 143.83

$30,000 POLICY**		
Ages	EE, EE+CH	EE+SP, FAM
18 – 24	$ 5.41	$ 9.49
25 – 29	$ 6.78	$ 11.55
30 – 34	$ 8.71	$ 14.43
35 – 39	$ 10.66	$ 17.36
40 – 44	$ 14.48	$ 23.10
45 – 49	$ 19.61	$ 30.79
50 – 54	$ 25.47	$ 39.58
55 – 59	$ 35.16	$ 54.11
60 – 64	$ 54.07	$ 82.48
65 – 69	$ 80.80	$ 122.57
70 – 74	$ 96.53	$ 146.18
75 – 79	$ 113.34	$ 171.38
80+	$ 141.07	$ 212.99

* Excluding the third pay periods in the months of July and December.

**Insured spouse & each insured dependent are covered at 50% of Employee Benefit Amount

Where to Get More Information

FOR INFORMATION ABOUT ELIGIBILITY AND GENERAL QUESTIONS	
Address	County of San Diego Department of Human Resources Employee Benefits Division 5530 Overland Avenue, Suite 210 San Diego, CA 92123
Hours	Monday through Friday, 8:00 a.m. to 5:00 p.m. (except County holidays)
Telephone	888-550-2203
Fax	858-467-9708
Mail Stop	O-7
Email	DHRBenefits.FGG@sdcounty.ca.gov

PLAN AND BENEFITS INFORMATION			
Carrier	**Group Number**	**Member Services**	**Website**
MEDICAL AND PRESCRIPTION DRUG PLANS			
Anthem Blue Cross HDHP Full Access HMO, Select HMO and PPO	275360	 866-207-9878 800-227-3771	**www.anthem.com/ca**
Kaiser Permanente HDHP and Traditional HMO	104301	800-464-4000	**www.KP.org**
HEALTH SAVINGS ACCOUNT (HSA) FOR HDHP PLANS			
Wells Fargo Bank	N/A	866-884-7374 (Monday – Friday, 5 a.m. to 6 p.m. PT)	**www.wellsfargo.com/hsa**
DENTAL PLANS			
Delta Dental PPO DHMO	 17214 76990	 877-688-3503 844-697-0579	**www.deltadentalins.com**
VISION PLAN			
VSP Vision Service Plan	107506	800-877-7195	**www.vsp.com**
FLEXIBLE SPENDING ACCOUNTS (FSA)			
ASIFLEX	N/A	800-659-3035	**www.asiflex.com**
LIFE AND AD&D INSURANCE			
MetLife Life Insurance	158540	800-638-6420 8:00 a.m. – 8:00 p.m. EST (M – Th); 8:00 a.m. – 5:00 p.m. EST (F)	**www.MetLife.com**
AD&D Insurance		800-638-2242 8:00 a.m. – 11:00 p.m. EST (M – F)	
VOLUNTARY BENEFITS			
Cigna Short-Term Disability Insurance Long-Term Disability Insurance		800-36-CIGNA (800-362-4462) 7:00 a.m. – 7:00 p.m. CST (M – F)	**www.Cigna.com**
Allstate Critical Illness Insurance		866-828-8501 (English) 800-211-5533 (Spanish)	**www.allstateatwork.com/mybenefits** Email: **AB-CustomerCare@allstate.com**
EMPLOYEE ASSISTANCE PROGRAM			
Anthem EAP	N/A	888-777-6665	**www.anthemeap.com** Company Code: County of San Diego